Making Sense of Health Care Commercialization and Liberal Utopias of Market-Driven Health Care: Theoretical Explorations in Karl Polanyi's Double Movement Concept as Critique of the Global Health Care Reform Industry

Pol. Sc. Kai Mosebach, Assistant Professor, Department of Health and Social Care, University of Applied Science, Ludwigshafen on the Rhine, Germany

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Kai Mosebach, Pol. Sc., Assistant Professor of Health Policy, Health Economics and Health Sociology, Department of Social and Health Care at the University of Applied Science, Ludwigshafen on the Rhine, Germany (Ernst-Boehe-Strasse 4; D-67059 Ludwigshafen on the Rhine).

Contact: kai.mosebach@hs-lu.de

„The purpose of studying economics is to learn how not to be deceived by economists.“

(Joan Robinson, Basel Lecture 1969, zit. n. Varoufakis (1998: Pos. 907)

CONTENT

I. Introduction[1]

In the last 30 years several waves of health care reform have hit high-income as well as middle-income countries around the world, aiming at making health care systems more efficient, responsive and fairer, to use criteria delivered by the World Health Organization's controversial 2000 World Health Report (cf. WHO 2000). Following the mainstream narrative, a plethora of market-driven- and market-style instruments should do the trick while public health (care) financing had been put under the stress of permanent austerity through globalization processes, market ideologies and neoliberal policies. This threefold process of political, economic and ideological transformation of health care states has been termed by some health care systems researchers as a global dynamic of ‚commercialization of health care' (cf. Mackintosh/Koivusalo 2005a; Tritter et al. 2010). In the first chapter of this article I will briefly sketch the common but variable pattern of market-style and market-driven reform policies throughout OECD health care systems since the double recession of the 1970s/ 1980s that adds up to a paradigmatic shift in health care policy that has been labelled competitive based cost containment policy (CBCCP) (cf. Gerlinger/Mosebach 2009). In the following section I try to make sense of this ‚global health reform industry' in applying three central Polanyian concepts (liberal utopia, fictitious commodities, and double movement). I will discuss the analytical fruitfulness of the Polanyian narrative of the Double Movement as a starting point for a political-normative critique of ongoing commercialization processes in the health care field by focusing, *firstly*, on the (liberal) utopian function of health economics to transform state-led and corporatist health care states into institutional varieties of competitive health care states. *Secondly*, I will apply the Polanyian concept of ‚fictitious commodities' to the question whether health, health care and the ‚social' body is in the process of becoming a fictitious commodity because of systematic repercussions of both the commodification of health care and the re-commodification of labour through neoliberal policies on the ‚health status' of individuals, social groups and social classes. *Thirdly*, I try to sketch a normative framework for criticizing health effects of health care commercialization and re-commodification of labour and discuss whether the Polanyian concept of the double movement has some analytical value in triggering an alternative health care policy agenda aimed at rebalancing social determinants of health in order to reduce social inequalities in health. I try to strengthen the analytical fruitfulness of these Polanyian concepts as a starting point of criticizing ongoing processes of health care commercialization by theoretically re-embedding them into a politico-economic framework. For results show that the Polanyian concept of liberal utopias for explaining the transformation of health care systems as well as the concept of fictitious commodity in order to understand the undermining of psychosocial conditions of health in due curse are quite convincing and analytically helpful. However, I maintain that the double movement concept's analytical power is in jeopardy if it neglects normative and cultural realignments in the institutional context of health and health care as it is embodied in

concepts of welfare (state) transition (cf. Lessenich 2008) and the transformation of the social meaning of health (cf. Brunnett 2009). More than that, I argue that the current commercialization of health care systems should be - in Post-Polaynian terms - understood as a process of disembedding and transforming health care states out of their fordist heritage (cf. Gerlinger 2006: 49ff.; Mosebach 2016: chapter II.3.). The article concludes that there is no social necessity for the countervailing self-protection of societies against the creeping commercialization of health (care). It is a political choice and requires the organization of countervailing powers against the social forces of health care commercialization inside and outside of the postfordist (competitive) health care state (see for similar conclusions: Deppe 2009).

II. Commercializing Health Care systems in OECD Countries: Towards a New Consensus in Health Care Policy

In this chapter I firstly sketch hypothetically common features of the new consensus in health care policy in OECD countries that are originated in overall modernization projects of New Public Management (Tritter et al. 2010; Pollitt/Bouckaert 2011) and Managed Competition (Enthoven 1988; Light 2000) respectively. Summarizing more extensively pursued work (cf. Mosebach 2016) the next sections show on the one side how the new consensus in health care policy triggers commercialization processes and how a Polanyian framework of interpretation could improve analytical insights into societal mechanisms and social forces triggering commercialization procession in OECD health care systems.

1. Paradigmatic Shift: Competition Based Cost Containment Policy (CBCCP) as a Hegemonic Modernization Project for OECD health care states

The history of market based health care reform of the last generation shows three overlapping common reform waves that have altered the institutional and organizational shape of OECD health care states fundamentally.[2] *Firstly*, the economic crises of the 1970s and early 1980s triggered a wave of administrative and supply side measures of cost containment policies in OECD health care states. Several governments from different sides of the political spectrum have been introduced budgets and public ceiling on health care expenses as well as co-payment, co-insurance and deductibles in order to contain the rising costs of public health care systems within a context of economic globalization (cf. Abel-Smith/Mossialos 1994; Ham 1997; Saltman/Figueras 1997; Tritter et al. 2010).[3] *Secondly*, the first wave has been supplemented by a second wave of health care reforms in the 1980s and early 1990s that tried to implement internal markets and market incentives in health care systems around the globe. Depending on the institutional traditions of each health care system market like reforms has been implemented either on the supply side or the demand side of the health

care market, thereby showing not only an institutional and organizational shift in OECD health care systems but also signaling a discursive reinvention of especially European health care systems through applying the language of health economics to the identification and solution of health care problems. While former command-and-control health care states (like the United Kingdom and Sweden) experimented with competitive measures between several health care providers, corporatist health care states (i.e. the Dutch and later the German health care policy) aimed at introducing competition in both the demand-side (competition between sickness funds) and the supply-side (competition between providers) of the health care market. The basic idea of this similar but different ways of politically regulated competition has been to strive for efficiency and productivity gains through competing networks of care that would be organized by third-party payers (in corporatist health care states) and purchasing agencies (in command-and-control states) respectively (cf. Ranade 1998; Moran 1999; Freeman 2000; Freeman/Moran 2000; Harrison 2004; Palier 2010; Rothgang et al. 2010; Klenk et al. 2012; Pavolini/Guillén 2013). *Thirdly*, comparative studies of health care systems change point recently to the rise of the health services consumer as a ‚redrawing of the patient' (Tritter et al. 2010: 42ff.) in order to response to her needs and wants by serving her preferences through (quasi-)market competition most effectively (cf. Saltman 1994; Henderson 2002; Mosebach 2005; Le Grand 2007). In concluding on this comparative studies of health care systems change my main proposition is that these three identified ‚waves' add up to a paradigmatic shift in health care policy in OECD health care states that we have labelled in a German context preliminarily ‚competition-based cost containment policy' (Gerlinger/Mosebach 2009: 13ff.; Mosebach 2016: chapter II.4.). Competition-based cost containment policy (CBCCP) is rooted in both external as well as internal preconditions of the health policy discourses that aim at maximizing the effects of public health care expenses. *Externally*, ‚neoliberal globalization' (Panitch/Gindin 2012) and the ‚dangerous idea' (Blyth 2013) of ‚permanent austerity' (Pierson 1994; Pierson 2007; Schäfer/Streeck 2013) have led to a retrenchment of welfare entitlements (cf. Hay/Wincott 2012), the implementation of state projects to modernize the role of the state in financing and providing public services due to prescriptive models of New Public Management (cf. Bode 2004; Bieling 2009; Pollitt/Bouckaert 2011; Klenk et al. 2012) and the rise of the postfordist Schumpeterian Workfare Regime in Europe (cf. Lee 2000; Jessop 2002; Hirsch 2005; Bieling/Buhr 2015). *Internally* the - politically desired - innovations in medical technology, the effects of demographic change and - sometimes - the undesired effects of provider moral hazard or (from a more conservative point of view) consumer moral hazard would lead to rising costs of health care if not balanced against both the economic requirements of international competitiveness and the realization of a patient-centered health care system. The latter goal should be realized through enhancing the ‚responsiveness to the patient's preferences' through ‚Quasi-markets' (Le Grand/Bartlett 1993; Le Grand 2007), ‚Public Competition', (Saltman/von Otter 1992; Saltman 2002) ‚Managed Competition' (Enthoven 1988, 2002; van de Ven 1996; Cassel 2002; Enthoven/van de Ven 2007) or ‚Embedded Competition' (Wille 1999). CBCCP strategies utilize

several market-like instruments to guide purchaser, provider and consumer behavior towards more efficient and effective health care service provision (competition, flat-rate reimbursement schemes, market-like contracting) while maintaining public health care budgets, regulate standards of health care service quality and provide market information to consumers and third-party payers (consumer's advocacies) to enable ‚purchasing for quality' (cf. Figueras/Robinson/Jakubowski 2005; Preker et al. 2007). Therefore, marketization of health care financing and provision is about politically regulated markets that try to ‚simulate' desirable but prescriptive effects of (perfect) competition by political regulation (cf. Mosebach 2013, 2016). To sum up, competitive-based cost containment policy

- …aims at making efficiency and responsiveness of health care provision by using competitive mechanisms in highly regulated health care markets
- …by regulating financial incentives of third-party payers, health care providers as well as users of health care services in order to simulate (neoclassical) ‚market' behavior (—> wants and needs of consumers') and setting quality standards
- …under the condition of restricted public health care budgets and competitive measures to allocate scarce resource
- … that leads to invasions of commercial interests and private for-profit providers in OECD-health care systems.

2. New Public Management and Managed Competition under Neoliberal Conditions: Five Steps to Commercialized Health Care

Historical trajectories of path-dependent development together with common tendencies of CBCCP in command-and-control as well as corporatist health care states culminate in convergent ways of institutional and organizational transformation (cf. Burau/Blank 2010; Rothgang et al. 2010; Tritter et al. 2010; Pavolini/Guillén 2013). While New Public Management (NPM) oriented health care reform measures have been applied in command-and-control health care states like England or Sweden, Dutch and German corporatist health care state adapted reform models of Managed Competition (MC) (cf. Harrison 2004; Blank/Burau 2010; Tritter et al. 2010; Hunter 2016). Both NPM and MC-reform models originated in a USA-reform context but soon proliferated around the globe (cf. Moran 1998; Light 2000; Mackintosh/Koivusalo 2005a). Although being applied to different realms of statehood NPM- and MC-reforms share some basic prescriptive norms and principles of ‚politically regulated markets' (cf. for a longer description: Mosebach 2016: chapters II.4. and III.2.). ‚Permanent austerity' and the transformation of the Fordist welfare state led to commercialized health care in OECD countries.[4] Health economists Maureen Mackintosh and health policy researcher Meri Koivusalo describe processes of health care commercialization as follows:

> ‚[Commercialized health care means, KM] the provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them,

> for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payment and private insurance. This concept of commercialization is thus wider than the ‚private sector' of provision and finance, encompassing, for example, commercial behavior by publicly owned bodies. It is also broader than ‚liberalization' and ‚marketization', each of which refers to a shift to market-led provision from state-led or state-constrained systems, and broader than ‚privatization', which refers to the sale or transfer of state-owned assets to private hands." (Mackintosh/Koivusalo 2005b: 3f.)

CBCCP aims, therefore, at making health care systems more efficient and responsive to consumer's health care needs and wants by strengthening both fiscal prudence and productivity gains through enabling or even maximizing cash income or profits in politically regulated markets. This new policy paradigm is best characterized as ‚regulating incentives' (Saltman 2002) or ‚regulating entrepreneurial behavior' (Saltman/Busse/Mossialos 2002) to realize such competitive behavior in order to enable ‚purchasing for quality' (Figueras/Robinson/Jakubowski 2005; Preker et al. 2007). Under the above mentioned neoliberal conditions of ‚permanent austerity', ‚welfare state transformation' and ‚globalization' the new policy paradigm of CBCCP has triggered not only economization trends within the public health care sector but also privatization and liberalization policies that transform both command-and-control and corporatist health care states into institutional varieties of competitive health care states, i.e. ‚public competition' (Saltman/von Otter 1992) models and ‚competitive corporatism' (Urban 2003) respectively.

Figure I. Continuum of Commercialized Health Care Financing and Provision

Management of costs and financial deficits	Financial Surplus (Cash income or profit)	Continuum of Economisation and Commercialization
No intention	No intention	Ideal health care provison
Screening costs of health care	No intention	Cost awareness
Reducing financial deficits	No intention	Duty to reduce costs
Reducing financial deficits	Cash income and profits allowed	First order commercialization
Reducing financial deficits	Maximizing profits and cash income	Second order commercialization

Own depiction; source: adapted and modified from Schimank/Volkmann (2008: 385f.) and Gerlinger/Mosebach (2009: 11ff.)

The new institutional and organizational context of politically regulated markets make third-party payers and health care service providers long to attract economically beneficial ‚patients' by manipulating their economic incentives (cf. Kühn 1993: 26ff.; Kühn 2004: 29ff.; Mackintosh/Koivusalo 2005b: 3f; Gerlinger/Mosebach 2009: 13ff.). However, if the quest for cash-income and/or profit becomes more important than medical and nursing standards in delivering health care services one can speak of first order or second order commercialization (see Figure I).

3. Who is in the Driving Seat? Neoliberal Counterrevolution, International Organizations and the Impact of Transnational Knowledge Networks of Health Economics and Business Administration

Although the evaluation of the impact of commercialized health care on both individual and public health is only in its infancy (but see for example: Mackintosh/Koivusalo 2005b: 13ff.; Braun et al. 2010; Panitch/Leys 2009; Braun 2014)[5] the question, nevertheless, has arisen which societal mechanisms and social forces have triggered the processes of commercialization within the health care sector.[6] While external conditions of institutional and organizational change are well understood (new welfare state, permanent austerity, neoliberal globalization) the institutional and organizational linkages of this macro social processes with meso level change in the health care system are still unclear. The so called ‚neoliberal counterrevolution' (Elmar Altvater) in economic and social policy started - as is well known and extensively researched - during both the Thatcher and Reagan administrations in Great Britain and the United States of America in the early 1980s. The question, however, remains how and through which social mechanisms the neoliberal counterrevolution proliferated well into the health care sector of OECD countries. While some critical health policy researchers point to the leading role of international organizations as the World Bank, the International Monetary Fund and the Organization for Economic Change and Development (OECD) in explaining these converging patterns through the imposition of ‚structural adjustment policies' (cf. Lister 2005: 43ff., 2013: 79ff.; Tritter et al. 2010: 54ff.)[7] I would suggest a different but related policy channel through which the idea of CBCCP has been spreading around the globe. *Neoliberal globalization* not only refers to economic and political processes of globalization but also to cultural and cognitive patterns being shaped by as well as constituting the former processes (cf. Lee 2003: 4ff.; see also: Hay/Marsh 2000: 7ff.). Summing up the content of the remainder of this paper I would propose that the health care policy reform discourse around the globe has been crucial for spreading globally the economic as well as political ideas of politically regulated markets (see for similar analytical ideas: Moran/Wood 1996; Freeman 2000; Buse et al. 2002; Harrison/Moran/Wood 2002; Marmor/Freeman/Okma 2009). In the following I try to disentangle this transnational knowledge network of health economics and business administration in an exploratory way using a Polanyian framework of interpretation and thereby making sense of the importance of guiding policy ideas in

times of institutional and organizational crisis (cf. Blyth 2002: ; Lessenich 2003: 29ff.; Hay 2006: passim). More than that, it can be shown that the ‚(neo-)liberal utopia' of politically regulated health care markets - notwithstanding its good faith in market efficiency - has detrimental effects on both the social inclusiveness of health care systems and the social determinants of individual as well as public health if health becomes gradually a ‚fictitious commodity' (see for a more extensive treatment: Mosebach 2016: chapter III.2.).

III. A Polanyian Framework of Interpretation: Double Movement, Fictitious Commodities and the Liberal Utopia of Health Care Commercialization[8]

For the purpose of this article it is analytically important to discuss if and how Polanyi's conceptualization of a ‚self-regulating market' (Polanyi 1944: 68ff.) is applicable to the ongoing commercialization of health care I tried to outline in the forerunning chapter. I agree with Mark Blyth's analysis (2002: 4) that Karl Polanyi's observation of a double-movement in economic history which the latter one had interpreted as an act of self-defense of the society against the damages and chaos being provoked by the rise of the market society in the 19th century does not stop with the rise of ‚embedded liberalism'. As Blyth (2002: ibid.) goes on to argue: ‚The contemporary neoliberal economic order can be seen as merely the latest iteration of Polanyi's double movement. It is an attempt once again to disembed the market from the society, to roll back the institutions of social protection and replace them with a more market-conforming institutional order.' Concerning the neoliberal transformation(s) of the health care state(s) it can be argued that the transformation of corporatist and command-and-control health care states into (variations of) competitive health care states follow the same institutional and organizational pattern. Blyth (2002: 6) is close to Polanyi analytically insofar as he tried to give ideas decisive influence in changing political and economic institutional orders. Karl Polanyi did not ignore the role of the state by implementing markets throughout the society but the main causal effect did come - at least in the interpretation of Blyth (2004) - from ideas as guiding principles in times of crisis. Blyth' (2002: 6) analytical framework also stresses the ‚politics of organized business' in disembedding the market from the society (for a similar argument see also: Leys 2003: 81ff.), which is compatible with Moran's (1999) proposition that health care is also about fostering capitalist growth and supporting for-profit organizations in health care. Therefore, the ‚liberal utopia' of a ‚self-regulating market' in health care can be thought of as proliferating game-changing ideas in the politics of health care financing and delivery.

1. Liberal Utopia of ‚Politically Regulated Markets': Policy Ideas as Guiding Principles in Times of Crisis

Karl Polanyi understood as liberal utopia the construction of an economic imagination by Adam Smith, David Ricardo and other thinkers of economic liberalism in the 19th century. However, he was also clear about the fact that „in reality it [i.e. the liberal utopia, KM] was handing over things to a definite number of concrete institutions the mechanisms of which ruled the day." (Polanyi 1944: 211, 1995: 283) Therefore, this proposition shows that Polanyi transferred indeed analytical power to ideas and economic discourses in explaining institutional (and organizational, I would add) change. Because the neoliberal disembedding did not start from scratch but within the institutional and organizational context of ‚embedded liberalism' the liberal utopia of efficient health care markets has not been constructed by referring to ‚free markets in health care' but through more applicable concepts of politically regulated markets. It seems rather impossible that the form of liberal utopia could be the same as in the 19th century when there had been no market society before. As Claus Thomasberger (2014: 18ff.) has convincingly shown neoliberal thinking had to start from the social reality of welfarism. Citing neoliberal doyen Friedrich August von Hayek he insists that the neoliberal assault upon the welfare state has at least to accept some aspects of this inherited institutional arrangement. He writes (ibid.: 20):

> ‚If planning for competition is regarded as necessary, a strong state is needed in order to organize markets. And they [i.e. neoliberal thinkers, KM] accept that the markets for the fictitious commodities have to be planned because they do not emerge spontaneously. In order to stabilize the labour market even Hayek proposes the introduction of a state guaranteed "equal minimum income for all" (Hayek 1960, 226, cf. also Hayek 1944/2001, 120). And the question of how to create a global monetary system becomes one of the most discussed and most controversial issues not only between Keynesians and their opponents, but also between the Austrian and the Chicago currents of the neoliberal creed.'

Consequently, from a neoliberal point of view the use of such an idea as ‚free markets' to undermine welfare state arrangements is not only unrealistic but absolutely unnecessary (see for arguments in favor of a strong ‚neoliberal state': Gamble 1988: 27ff.; Harvey 2005: 64ff.; Jessop 2016: 211ff.). On the discursive level of conceptual ideas about market competition in health care two basic discursive condensations have influenced market-led reform policies in Europe: the proposals of Alain C. Enthoven concerning the ‚internal market' strategy of the late Thatcher government (Enthoven 1985, 1991) and the his proposal for reforming the Dutch health care system (Enthoven 1988). Similar ideas of ‚quasi markets' in health care of late health policy adviser Julian LeGrand (LeGrand/Bartlett 1993; LeGrand 2006, 2007) had an sustainable impact on the ‚reinvention of the NHS' (cf. Klein 2013: 210ff.) by the New Labour governments (cf. Exworthy/Freeman 2009: 170; Tritter et al. 2010: 154; Klein 2013: 148f).[9] Mirroring and partly importing market ideas from England the Swedish experiments with market-led health care reform policies (cf. Harrison 2004: 88ff.; Tritter et al. 2010:

154) resulted - at least for a part - in the stylized marketization model of Richard Saltman and Casten von Otter which they coined ‚Planned Markets' (Saltman/von Otter 1992).[10] In regard to market ideas for the Dutch health care system the so called ‚Dekker commission', led by the Chairman of the Board of Philips Corporation, played a kind of entrepreneurial role, referring to market ideas both of Alain C. Enthoven (1988) and Dutch health economists Wynand van de Ven (1987, 1990, 1991, 1993) (cf. Harrison 2004: 136f.). Finally, in German health policy reform discourse two important prescriptive models of market competition in health care stand out: one of the so called ‚contract-based competition' (cf. Cassel 2002; Cassel et al. 2006), mainly adapting Managed Competition-ideas of Alain C. Enthoven to the German context, and the other detailed prescriptive model of ‚Embedded Competition' (cf. Wille 1999)[11] by the long-term Chairman of the *Governmental Advisory Council for the Assessment of Developments in the Health Care System.* It is not possible to go into details here (see Mosebach 2016: chapter III.2. for a systematic comparison) but it might suffice to conclude that all ‚good faith models' of politically regulated markets share, *firstly*, the assumption that state-led planning is inefficient as a tool for allocating resources to the benefits of ‚health consumers'. *Secondly*, regulated or managed competition between several health plans should make productivity gains possible and public health care systems both more efficient and responsive to serve patient's needs and wants. *Thirdly*, in order to reach that goal state-led regulation is required to balance the manifold market inefficiencies in health care and to earn the fruits of competitive behavior in health care financing and provision. Regarding this huge array of ‚market inefficiencies' and plethora of ‚market-led reform models' which try to overcome those ‚market distortions' through different but similar models of ‚politically regulated markets' the question arises how can it be that commercial interests and privatization processes seized the day and led - as I suggest - to a converging process of commercialization of OECD health care systems? This is a rather puzzling problem for neither of the above mentioned ‚marketeers' nor any related government in power pledged support for a commercialized health care system as defined above. It is my main proposition that there are several external conditions that make impossible the good faith models of politically regulated markets. Under economic conditions of permanent austerity, deflationary pressures and the quest for international competitiveness on the one side and mounting income inequality and tax evasion on the other side public health care expenses are flattening out while private health care expenses are soaring (cf. Mosebach 2010: 21ff.; Schmidt/Cacace/Rothgang 2010: 37ff.; OECD 2015: 171, table 9.10). Reflecting the presence of further allocative distortions as provider as well as consumer moral hazard it is not surprising that health care policy decisions press for more productivity gains through competition-based cost containment policies. However, because health care services cannot be rationalized as far as physical goods because the substitution of human services for capital goods is limited, so are efforts to control public health care expenses (cf. Kühn 2001: 16f.; Baumol 2012: Pos. 298ff.). Economically, there are only two ways to adapt to this situation if productivity gains are qualitatively and higher public expenses fiscally (or politically) limited: (i) privatization of service

provision and/or (ii) capitalization of health care service provision through product and process innovation (cf. Leys 2003: 87ff.). Further, it is doubtful that private health care providers could by state regulation be governed to serve the public interest. For, there is an underlying contradiction at work in basically all models of ‚politically regulated markets' that health economists Anne Mills (Mills et al 2001: 6) described appropriately as the irritating premise that after the administrative power of the state had been undermined through NPM-based criticisms of traditional state-planning procedures and by unleashing private service providers to the field of health care the resulting ‚regulatory state' (Moran 2003) is powerful enough to ‚rein in' unwelcome market behavior of those (for-profit) private providers.[12] Additionally, the flawed premises about the steering capacity of the ‚regulatory state' and the stability of ‚planned markets' can also be criticized by referring to Colin Leys' (2003: 87ff.) analysis of the ‚private lives of commodities' which undermine the public interest when finally unleashed into the public sector. Commodities alter the relationship of producer and consumer of public services. Once ‚a good or service is being produced under capitalist market conditions, very strong tendencies come into play to change ist character; it becomes subject to a „product cycle", i.e. a process of development, maturity and eventual replacement by a „new product".' (ibid.: 88) And this capitalization process is driven mainly by economic rather than health related motives and incentives.[13]

2. Health and Health Care as ‚Fictitious Commodities': Rising Social Inequalities in Health

The concept of ‚fictitious commodities' by Karl Polanyi is a straightforward one that enables a fundamental critique of the negative and disintegrating effects of a capitalist market society. In the *Great Transformation* he developed the idea that the subjugation of labour, land and money to the laws of the system of self-regulating markets undermines the social conditions of their very existence. He wrote:

> ‚The crucial point is this: labour, land, and money are essential elements of industry; they also must be organized in markets; in fact, these markets form an absolutely vital part of the economic system. But labour, land, and money are obviously *not* commodities; the postulate that anything that is bought and sold must have been produced for sale is emphatically untrue in regard to them. In other words, according to the empirical definition of a commodity they are not commodities. Labour is only another name for a human activity which goes with life itself, which in its turn is not produced for sale but for entirely different reasons, nor can that activity be detached from the rest of life, be stored or mobilized; land is only another name for nature, which is not produced by man; actual money, finally, is merely a token of purchasing power which, as a rule, is not produced at all, but comes into being through the mechanism of banking or state finance. None of them is produced for sale. The commodity description of labour, land, and money is entirely fictitious.' (Polanyi 1944: 72; 1995: 107f.)

Although Karl Polanyi did not deal with health in general or health care in particular in his great oeuvre it is nevertheless possible to conceptualize or understand health and health care as ‚fictitious

commodities‘ if embedded in self-regulating markets. The conceptual connection is that health as an individual condition is literally embodied in the physical and social conditions of the respected person (cf. Turner 2004; Blaxter 2010). Therefore, the concept of health shares as much common ground with the concept of labour in Polanyian terms as it is embodied socially in an equal way. Further, health is as the other fictitious commodities not produced for being sold on the market. From a health sociological point of view it is absolutely undeniable that the seemingly individual status of one person’s health is determined by several political, economic and social conditions (cf. Albrecht/ Fitzpatrick/Scrimshaw 2000: Berkman/Kawachi 2000; Marmot/Wilkinson 2006; Berkman/Kawachi/ Glymour 2014) which cannot be reduced to an individual health production function as fantasized by some scary health economists (see for example: Breyer/Kifmann/Zweifel 2005: 73ff.). Consequently, these very conditions are embedded within the institutions and organizations of the wider society. If these societal context has been commercialized, i.e. subjugated to the laws of self-regulating markets, the social conditions of individual health become undermined in a similar way. Due to health sociology’s state of the art the most important social determinants of health are: daily living conditions (e.g. healthy places, fair employment and decent work, social protection, universal health care) and the power-money-and-resources nexus (fair financing, market responsibility, gender equity and political empowerment) (cf. WHO 2008). It is of course not possible here to assess and describe extensively the detrimental effects of neoliberal globalization on individual and public health in general (see for a overview: Navarro 2002; Lee 2003; Kawachi/Wamala 2007). On the one side, it should suffice here to point to the widely discussed and empirically evidenced widening of social and economic inequality in today's crisis ridden capitalist democracies, which is leading to widening social inequalities in health (cf. Navarro 2004; Wilkinson/Pickett 2010; Stiglitz 2013; Stuckler/Basu 2013; Piketty 2014; Thomson et al. 2015). On the other side the commercialization of health care influences the social conditions of individual and public health in several ways. *Firstly*, the commercialization of health care worsens the working conditions of physicians, nurses and especially lower status ancillary staff through the more flexible organization of health care service production. Increasing the patient throughput in order to reduce costs and improve the efficiency of health care service provision and/or optimize the organization’s cash income or profit leads to productivity gains but also means the intensification of care work (cf. Hasselhorn et al. 2005; Braun et al. 2010). *Secondly*, commercialized health care is built on the mythical premise that health care consumers are - at least in most part - responsible for their own health through rational decisions (see for example: Gerthmann et al. 2004: 187ff.; Breyer/Zweifel/Kifmann 2005: 73ff). From a health sociological perspective this proposition is rather (neo-)liberal nonsense because individual and public health are determined by political, economic and social conditions upon which the individual’s influence is inversely empowered to her social status (cf. Kühn/Rosenbrock 1994). However, contrary to such health sociological evidence it could be easily shown that both (individual) good health has become a marker of social status and reaching it a moral duty for everyone, thereby discriminating those who do not have access to healthy

social conditions of work, housing, leisure, money, power and so forth (cf. Kühn 1993; Lupton 1995; Peterson/Lupton1996; Lessenich 2008; Brunnett 2009). *Thirdly* and contrary to the political aims and ethical values being attached to competition and choice I maintain the above mentioned ‚good faith market models' in health care are reproducing the often criticized fact of social stratification of health care utilization (see for some ‚facts': Le Grand 2007: 34f.), rather than being a market socialist strategy to an universally health care system (for related ideas of ‚market socialism' see: Le Grand (1989). The economic conditions of ‚permanent austerity' and ‚deflationary pressures' make it - to say the least - rather improbable that the poor and the lower-strata citizens - which are in the focus of Le Grand's and Saltman's market socialism - would be supported and empowered by an ever slimmer workfare state. Summing up the arguments, Polanyian analysis tells us that ‚economic intrusion' (Pierre Bourdieu) into European health care states has to take place before the background of the historical fact of ‚welfarism' (cf. Thomasberger 2014) so that models of politically regulated health care markets fit best in unleashing commercial interest and give them best arguments to do so in a European context. This is not to argue that there are no differences between the US-health care system and European traditions of welfarism in health care but it stresses to scrutinize common trajectories and transatlantic system convergence more seriously than usually pursued in comparative health systems research (see for a more systematic treatment: Mosebach 2016: chapter II).

3. De-Commercialization and De-Commodification as Countervailing Powers: From Commercialized to Re-Embedded Health Care

In Karl Polanyi's analysis of the *Great Transformation* from the 19th to the early 20th century the concept of the double movement of society is at the core of his argument. His main thesis is that the unleashing of the system of self-regulating markets on the ‚fictitious commodities' of labour, land and money triggered a political, economic and social reaction by the oppressed social groups and classes, i.e. a social process that he termed the ‚self-protection of society' (cf. Polanyi 1944: 163ff., 1995: 224ff). As Karl Polanyi suggested and also Robert Alford has shown in his seminal analysis of New York's health care reform process, there are indeed oppositional but ‚oppressed interests' of health workers and patients (cf. Alford 1975: 218ff.) that stood out against the ‚challenging interests' of corporate rationalizers and/or bureaucratic controllers, whereby the latter groups nowadays have become the *new* dominant structural interests after a generation of market-led reform strategies in OECD countries. The still oppressed structural interests of health workers and patients have been and could be the ‚bearers' of ‚re-embedding' strategies. However, I would suggest that the oppressed interests have been drawn into the wider hegemony of neoliberal marketization by the silent but meaningful transformation of their respective education systems as well the ‚redrawing of the patient as consumer' (cf. Tritter et al. 2010: 41ff.). On the one side there is - at least for Germany - of special interest that alongside the process of marketization and commercialization of health care there is a paralleling process of professionalization of administrative, medical and nursing workers in the health

(care) field through the expansion (as well as transformation) of tertiary education that reproduces ideologies as well as practices of neoliberalization. To be precise, in economic, management, medical and health sciences departments the optimization of health care is indeed the common topic and circumscribes the discursive boundaries (to paraphrase Michel Foucault here) under which the special interests of economists, business managers, physicians and nurses could compete and will be teached (cf. Busse/Schreyögg/Stargadt 2013; Krampe 2014). On the other side of the coin the ambivalent ‚redrawing of the patient as consumer' (Tritter et al. 2010: 41ff.) which is essential for market-led reform strategies has to be counterbalanced in showing the macroeconomic as well as macropolitical suppositions of empowering voice instead of choice. For it is a fundamental mistake of good faith models of health care markets that under neoliberal conditions it would be probable to strengthen the voice of all by inserting choice for all in the health care field while the same conditions would raise inequalities of income, power and knowledge which will broaden necessarily social inequalities in health. Consequently, it is of outstanding importance that re-embedding health care requires strategies of macroeconomic alternatives to neoliberal orthodoxy and income redistribution through taming financial markets, inclusive growth strategies and policies aiming at the de-commodification of labour beside internal reform measures of de-commercializing health care service provision.

IV. Strength and Weakness of a Polanyian Critique of Commercializing Health Care States

How could Polanyi's concepts help to understand processes of commercialization in OECD health care systems? In this explorative paper I tried to apply the concepts of ‚liberal utopia', i.e. the idea of a self-regulating market and its propagation by an intellectual stratum of society, ‚fictitious commodity' and ‚double movement' to the health care sector of ‚(late-)modern' or ‚post-fordist' capitalist democracies. Have they made a difference in analyzing ‚market-led' reform policies for the health care field? I think they have and this for three reasons. *Firstly*, the idea of ‚liberal utopia' can help focussing on the role of conceptual ideas and prescriptive discourses in legitimizing both the ‚economic imperialism' of the *homo economicus* into the field of health care and the prescriptive appropriateness of ‚market-led' reform policies. In combining analytically ideas, interests and institutions this Polanyian (but not only his) insight enables to understand that the role of ideas is mostly to ‚creatively destruct' (Joseph Schumpeter) ideas in crisis as has been argued by all ‚marketeers' concerning state-planning and (most of them) state-led health care service provision. Therefore, this picture fits well into the overreaching analytical framework that historically reconstructs a kind of neoliberal counterrevolution, being underway since the crisis of the late 1970s (cf. Plehwe/Walpen/Neunhöffer 2006; Mirowski/Plehwe 2009; Birch/Mychnenko 2010; Crouch 2008, 2012, 2016;

Streeck 2013; Mirowski 2016). I have tried to shown - at least as far as possible in a short paper - that in times of globalization the liberal utopia of health care marketization is a transnational phenomena and has to be reconstructed accordingly. Therefore, Polanyian concepts can be melt together with or be understood as complementary to comparative analysis of a transnational health reform discourse (cf. Ham 1997; Saltman/Figueras 1997; Moran 1999; Lee 2003; Lister 2005, 2013; Blank/Burau 2010; Tritter et al. 2010). However, the analytical idea of ‚liberal utopia' has to be amended by a thoroughly analysis of actors interests and institutional systems in order to understand both the impact of ‚liberal utopia(s)' in health care and their very existence. To put it in another way, prescriptive models never enter the institutional and organizational reality of health care systems in full scope but are implemented by bargaining, political exchange and by chance and virtue of capable policy entrepreneurs (Moran 1998: 20ff.; Harrison/Moran/Wood 2002: 17ff; Crouch 2005: 74ff.; Lessenich 2003: 29ff.). Therefore, the ideational analysis of ‚liberal utopia' in health care (and beyond) have to be supplemented by a policy analysis that cuts deeper; there are many policy models to choose from but it has not been possible to do this here (cf. Béland 2011; Mosebach, in preparation). *Secondly*, the idea of health and health care as ‚fictitious commodities' fits very well into the overall picture of commercializing health care systems. Because individual and public health are determined by political, economic and social conditions the commercialization of health care and the re-commodification of labour through neoliberal economic and social policies means that individual and public health as well as the institutions and organizations of health care are driven by politically constituted but ‚self-regulating markets' more than ever. Their supposedly impact has been rising social inequalities in health in OECD competitive health care states. *Thirdly*, the idea of the double movement has been conceptualized as requiring a countermovement that aims at de-commercializing health care provision. It has been shown that on the one side processes of re-embedding are continuously taken place in health care politics due to the continuous resistance of (‚oppressed') oppositional interest and groups. On the other side it has also be shown that the inclusion of health care personnel into the neoliberal hegemony by tertiary education and management business techniques in order to optimize clinical pathways and care processes has limited the re-embedding process so far. The same is true for ‚redrawing the patient as consumer' which has strengthened social inequalities in health due to the dominant neoliberal conditions. To acknowledge and transform detrimental neoliberal conditions and macroeconomic contexts of both ‚politically regulated markets' and the ‚countervailing powers' of patient involvement (voice!) is essential if these protean processes of re-embedding should result in a process of de-commercialization of health care and reduced social inequalities in health. *Finally*, to apply Polanyian concepts to processes of health care commercialization requires to theoretically reassess societal processes beyond the reach of Polanyi's analysis (see Mosebach 2016: chapter II.3.).

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ENDNOTES

[1] For a longer and more systematic treatment of the issues summarized in this paper see my recent publication: Kai Mosebach (2016): Health Care Commercialization, Health Economics and the Rise of the Competitive Health Care State. A Post-Polanyian Critique of Competitive-Based Cost Containment Policies in European Health Care States. Discussion Paper. Department of Social and Health Care. University of Applied Science Ludwigshafen on the Rhine. Final Draft (December 2016), accessible at: researchgate.net.

2 The analytical concept (and fruitful metaphor) of the health care state has been invented by British political scientist Michael Moran (1999) in his historical comparative study of the rise and transformation of the US-American, British and German health care system since the late 19th century. His main analytical proposition is that statehood and the institutions of the wider state apparatus in capitalist democracies respectively did and do play an important role even in such health care systems that have been labeled in comparative health systems research as corporatist or market-based health care systems (cf. Moran 2000). I have described Moran's innovative analytical concept as well as my analytical modification of it more extensively in two earlier publications (cf. Mosebach 2009; 2016).

3 This should not suggest that rising health care costs are in any case problematic. To the contrary, it is often a misleading argument that health care costs are rising because it depends how to measure ‚health care costs'. The basic argument of the so-called globalization narrative is that if taxes and social insurance contributions did rise this would lead to a reduction in (international) competitiveness. However, such an argument is both theoretically incoherent as rising costs also do have positive macroeconomic effects and empirically wrong as public health care expenses only account for a part of total cost of health care (cf. OECD 2015: 167ff.). Nevertheless this narrative marks a kind of ‚entrance price' one has to pay if admitted to the higher echelons of health care policy making. I cannot work out these problematic way of conceptualizing health care costs here (see: Mosebach, in preparation).

[4] Some critical health economists and health sociologists apply the theoretical concept of 'commodification' to similar observations in OECD health care systems (cf. Leys 2003; Henderson 2002; Kühn 2004; Reich 2014). Without going into theoretical details here (but see: Mosebach, in preparation) the use of commodification as an analytical concept sometimes only refers to systems of totally privatized health care against still publicly financed and regulated health care provision. However, this conceptual specification misses the analytical point put forward by Maureen Mackintosh and Meri Koivusalo (2005b) that commercialization processes could also be found within publicly financed and organized systems of health care provision. However, it has to be conceded that commodification is also used as a more or less interchangeable concept to commercialization, coming only from another intellectual strata of health system research. While the concept of commodification stems from Classical Political Economy the analytical idea of commercialization has its roots in Industrial Economics (cf. Leys 2003: 81ff., in contrast to Koivusalo/Mackintosh 2004: 24ff.; see also Endnote 6 below, concerning the overlapping concepts of commercialization and economization).

[5] Concerning the methodological implications to measure and asses commercialization effects see my considerations in an early explorative paper (Mosebach 2010: 53ff.).

[6] The concept of health care commercialization is in the scientific literature often equated with processes of economization within the health care state, making the concept of economization somewhat fuzzy. Therefore, I suggest to overcome such a conceptual identification because policies of economization cannot be avoided in a publicly financed health care system, even if there are no commercialization processes at all. This conceptual differentiation should make the problems and dynamics of commercialization processes in regard to more fundamental problems of necessary economization within publicly financed health care systems more clear (cf. Harrison/Moran 2000; Kühn 2004; Mackintosh/Koivusalo 2005).

[7] Reflecting on the health impact of the recent Eurozone crisis and the imposing of structural adjustment policies on crisis-ridden economies in Europe the European Commission, as part of the well known ‚Troika' that has implemented such draconian economic and social policies had to added to that list of international organizations (see to the detrimental health effects of these European structural adjustment policies: Stuckler/Basu 2013; Thomson et al. 2015). Additionally, the subjugation of the OECD under these association of neoliberal commanding heights is as much doubted as this top-down-approach misses the importance of the lower depths of nation state politics for shaping the outcome and output of international organizations.

[8] After finalizing the paper I discovered an early application of Karl Polanyi's analytical conceptualizations to the phenomena of health care commodification. Health economist Maureen Mackintosh (2003: 30f.), in an early ‚synthesis paper' of an ongoing research project which finally led to the already cited publication (Mackintosh/Koivusalo 2005a), speculated in a similar way about health care as a kind of ‚fictitious commodity' as I did. This theoretical work has not been continued by her, however.

[9] The most important commission being installed to review the English NHS has been the so called ‚Wanless Commission', chaired by the Chief Executive of the National Westminster Bank. It focussed on ‚Securing our Future Health'. However, it draw heavily on personal as well as ideological discourses out of the Department of Health (cf. Klein 2013: 217). Therefore, both health policy advisers to the prime minister Tony Blair, Simon Stevens, since 2014 he is Chief of the NHS in England, and Julian Le Grand respectively, could be thought of as symbolizing discursively the marketization strategy by the government, although I concede that such a conclusion might be somewhat contestable.

[10] Concerning the Swedish early 1990s market reforms one important international influence has been a review of the Swedish health care system commonly authored by health economists from at least four countries: Canada, England, Germany and the Netherlands. Interestingly the review has been written by both neoliberal as well as social democratic (liberal in the US-american sense) health economists, e.g. market sceptic Robert G. Evans from Canada and neoliberal health economists J. Matthias Graf von der Schulenburg from Germany. It has been commissioned by the (neo-)liberal *Centre for Business and Policy Studies* (SNS) in Stockholm (see Harrison 2004: 88).

[11] The market concept by health economist Eberhard Wille draws heavily on health economic basics of German *ordoliberalism* (see for example: Herder-Dornreich 1994). I applied the term ‚embedded market' to that concept because its prescriptive value is that it is very close to the institutional and organizational realities of the German health care system and ‚awaits' implementation. Due to his administrative role as Chairman of the mentioned Advisory Council his proposals seem to be be more differentiated and modest in comparison to the proposals of the group of proponents of the other German market reform concept (‚Vertragswettbewerb') which is related to the scientific Think-Tank (WIdO) of one of the biggest group of sickness funds being represented by the Federal Association of General and Local Sickness Funds (AOK-Bundesverband). However, concerning the ideas and goals of ‚politically regulated markets' they share widely many principles and values of market competition in health care (cf. Mosebach 2016: chapter III.2.).

[12] It has to be conceded, however, that Anne Mills and colleagues (2001) argue for limitations about implementing new public management strategies in health care systems of developing countries. However, I maintain that such an argument is also applicable to high-income countries (see Mosebach, in preparation).

[13] This principle is very well detectable on the global market for pharmaceuticals where for-profit enterprises strive for ‚innovations' that aim more at maximizing profit and preserving monopoly rights than reaching for medical progress (cf. Angell 2005).